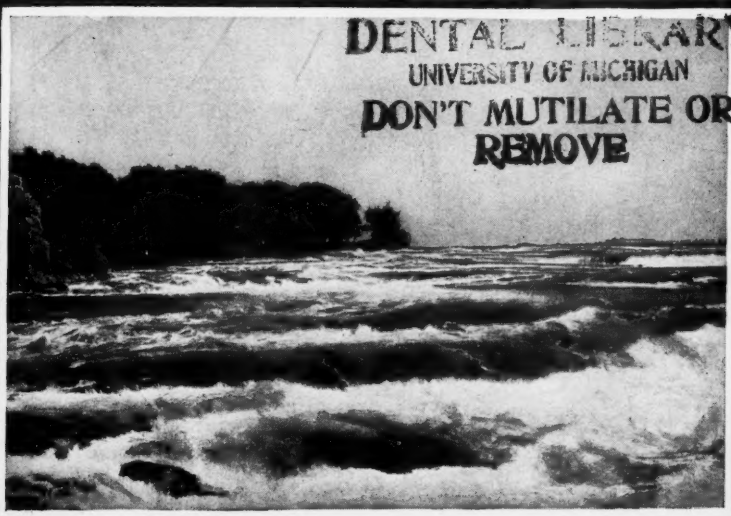
THE DENTAL DIGEST



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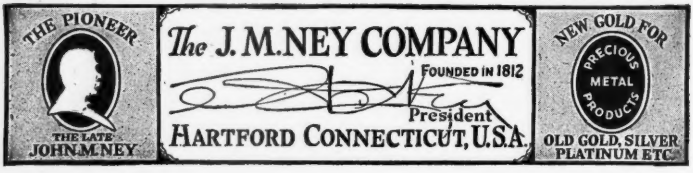


THE
DENTAL DIGEST

Vol. XXVIII OCTOBER, 1922 No. 10

Is the Medico-Dental Profession on the Road to Self-Elimination?*

By H. P. Saperstein, D.D.S., Cleveland, Ohio

It is remarkable how at times a highly organized person interprets in a single phrase or sentence the spirit closeted in the minds of a whole nation, community, or profession. In the World War every good American felt that he was fighting for some great altruistic cause. Nevertheless, even in moments of lofty intuition very few were able to define what that cause really was until President Wilson delivered his address which contained the famous expression, "To make the world safe for democracy."

In like manner Dr. Frederick B. Moorehead proved the Savior of the Medico-Dental profession when in a paper read before the Chicago Dental Society, he said, "The true aim of Dentistry is ultimately to eliminate itself."

In that same paper he went on to say: "The vision of the doctor is not of a day when he will have a specific for every ailment and disorder, but rather of the possibility of man exempt from ailments and disorders. The true physician and dentist are not engaged in "doctoring." Their business is to get at the truth and to guide society in the application of truth in the realm of physical well-being." The Medico-Dental profession with its centuries of tradition and dignified noble system of ethics may justly claim this great expression of Dr. Moorehead as the cause for their endeavors and labors. But though every honest physician and dentist knows the sanctity of his calling, his moral obligations, his endeavors toward achieving that result, yet no other man before produced a motto which so clearly defines his devotion to the physical welfare of society.

Now, the question that arises is this: Is the Medico-Dental profession really on the road to self-elimination, or is it merely adopting this as an ideal, a dream which does not bring us any nearer to its realization?

"The attack is wholly on the posterior problem. The anterior prob-

* Read before the University Fellowship Club, Chicago, March, 1922.

lem is not seriously considered," is another of Dr. Moorehead's statements on the same subject.

Is that really so?

That the Medico-Dental profession has made an immense progress in the last two or three decades is indisputable. The great supply of concrete information and laboratory effects verify this. The Wasserman and various other complement fixation tests, and the Röentgen rays are of great diagnostic value. Radium, the discovery of which dates not far back, proves successful in many cases of malignancy. These advancements strengthen the attack on the posterior defensive problem. But are we not progressing along the anterior offensive problem? What about Prophylaxis, Anti-toxins, Serums and Vaccines? Are they not advancements in the profession which strengthen the attack on the anterior problem? Is not the profession taking the offensive?

Are Diphtheria and Tetanus known today? Unfortunately they are, but not on account of ignorance on the part of the physician.

There is no doubt that there is also noticeable an advance in the pursuit and discovery of the causes of most of the diseases. Is it true that as yet the profession has not gone so far along these lines that there is no room for improvement? But I hope I am not too optimistic when I say that the Medico-Dental profession can lay claim to a knowledge of at least a great number of the causes that lead to almost any disease with the exception of a small percentage of ailments whose etiology is yet entirely obscure.

Now, the point I want to emphasize is this: If the Medico-Dental profession will ever attain its aim of self-elimination at the present stage of knowledge there should be a decided decline in physical ailments and disorders, and consequently a decrease in demand for doctors; if biochemistry will ever solve the problem of medicine and dentistry at the present stage of advancement in chemistry, at least one-half of the problem should have been solved; if professional self-elimination depends upon a knowledge of causes and prevention of diseases, self-elimination by now should be in process and not merely a dream.

"In an examination of 260 Maori skulls, all from an uncivilized age," Pickerrill states, "I have found carious teeth in only 2 or .76%."

"Magitot examining the skulls of the Paris Museum," continues the same author, "found no caries of teeth in the following races: Mexicans, Aborigines of Australia, Madagascar or New Caledonia." The Esquimaux, according to the same author, show a rate of 1.4% dental caries, while residents of Baden and Hamburg show a rate of 98.75% and 96.40%, respectively.

To think that the salvation of the profession lies in the hands of the future biochemist seems logical. But why wait for startling discoveries, when the study of the modes of life of the Esquimaux is easily within reach? How much of biochemistry did the uncivilized Maori, Mexicans and Esquimaux know?

If they could work out their own salvation and practically eliminate dentistry, more reason that we could do the same, having the advantage over them of our scientific facts which they lack. Our modes of life are such as make for degeneration and retrogression.

The program of medicine and dentistry will continue to develop along defensive rather than offensive lines so long as the public will not fully co-operate with the profession by changing its modes of life and its attitude toward health. The public is without doubt greatly responsible for the progress or decline of the profession.

Negligence in a community calls for an improved fire department. Hostility among nations calls for a well-organized army and navy. So also unnatural modes of life and capricious dictates of appetites among civilized people call for a large defensive army of doctors. The fire department cannot eliminate itself as long as members of the community are careless in handling fire. The army and navy cannot eliminate themselves unless the nations first abandon hostilities. Neither can the Medico-Dental profession eliminate itself so long as the public lacks that spirit of co-operation, sacrifice, and self-denial which are so necessary for its own physical welfare. Preventive medicine and dentistry today have reached a fairly high point of achievement, but everywhere can be seen that stubbornness on the part of the public which is not only detrimental to the labors of our scientists, but is also an obstruction to the public's well-being. Had the public submitted itself to apply all the known principles of prevention, the Medico-Dental profession would be right now well on its way to self-elimination.

The majority of people insist upon using tobacco though conscious of its evil effects. Many people insist on overeating just to satisfy their appetite, though fully aware of the dangers which go hand in hand with such a practice.

Let us now consider syphilis which is without doubt the worst of social diseases. Not only does it wend its morbid way and affect individuals, but also households, cities, states, nay, more than that, even nations are more or less afflicted with this horrible disease. This disease can almost entirely be eliminated, and why isn't it eliminated up to the present? Is it on account of the lack of offensive attack on the part of the physician? I would go a little further and ask: Is it on account of the lack of co-operation of the cities, the states, the countries? No, these have lent their most valuable aid in this if in no other connection.

And what result do we get? The average person knows its causes and prevention and yet our hospitals are full of those afflicted with syphilis of various stages, and the complications that attend this disease. Again the average person knows the importance of mouth hygiene for prevention of dental caries, yet insists upon neglecting this important factor. The average layman knows from the experience of others, if not his own, that a small cavity in a tooth if not taken care of immediately is followed by exposure of pulp, gangrene, alveolar abscess or cyst, and terminates in the loss of the tooth. And yet how many teeth are lost by being allowed to go through these processes. The average mother knows that the child artificially fed undergoes a period of adjustment and malnutrition. She also knows the sad results thereof. Yet she insists on artificial feeding, in many cases sacrificing the child's health for the sake of personal convenience.

The layman of today is not ignorant as some may claim. If he is, it surely is not the fault of the Medical profession. The layman knows the possibilities, but is too unwilling to depart from his habits.

There is great truth in this paragraph of Vicente Belasco Ibanez: "People like to delude themselves. They refuse to think of death in the midst of their happiness. People all consider themselves immortal. A man knows all along he is going to die, but it is never real to the moment."

What is true in regard to death is also true in regard to disease. It is human nature. People do not want to think of the possibilities of losing their health in the midst of their pleasure.

There is no royal path that leads to achievement of any kind. Achievement in any line of human endeavor demands sacrifices. Good health is something to be achieved and this can be accomplished only at the sacrifice of our own pernicious habits. It is not the doctor, the chemist, bacteriologist, and public hygienist alone that are going to solve the elimination problem.

The public is invited to co-operate with the profession for its own physical welfare and that of the future generations, by learning and following all the laid down principles of hygiene and prevention of medical and dental disorders.

Medicine and dentistry are materially progressing.

Medicine and dentistry are on the road to self-elimination.

"The true aim of dentistry is ultimately to eliminate itself," is the emblem physicians and dentists pay homage to, the motto to which they owe their high moral status.

We impatiently await the day when co-operation on the part of the public will help make this ideal a reality.

6912 Kinsman Road.

A New Dental Splint

By Herbert M. Vanderbilt, D.D.S., Suffern, N. Y.

Whenever I used to see a poor chap rigged up with an interdental splint, I felt sorry for him.

He could not talk, he could not swallow. Did you ever try to swallow with your mouth pried wide open? He could not smoke, and certainly was unhappy.

The patient who has his jaws ligated to reduce a fracture is just as much out of luck, for he can do very little, and if he has to sneeze or is taken with a fit of vomiting he is in a dangerous condition. A lot of the soldiers during the world war, who were ligated, were strangled to death, just because no one was near to cut the ligatures and give them a chance.

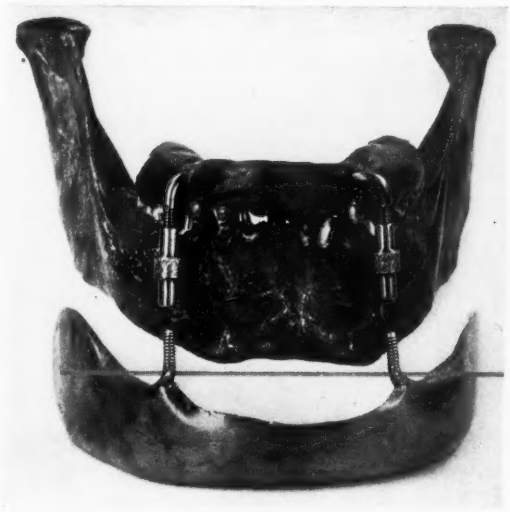


Fig. 1

Because of all this I hope the Vanderbilt Splint I am sending you will prove to be humane and a good splint in every way. This splint can be made of cast aluminum and stock castings kept available at the supply houses.

The tray (Fig. 1) should run down to gingival margin on the lingual side and be quite stiff.

I would suggest making the splint in three or more sizes to care for different size patients, say Nos. 1, 2 and 3.

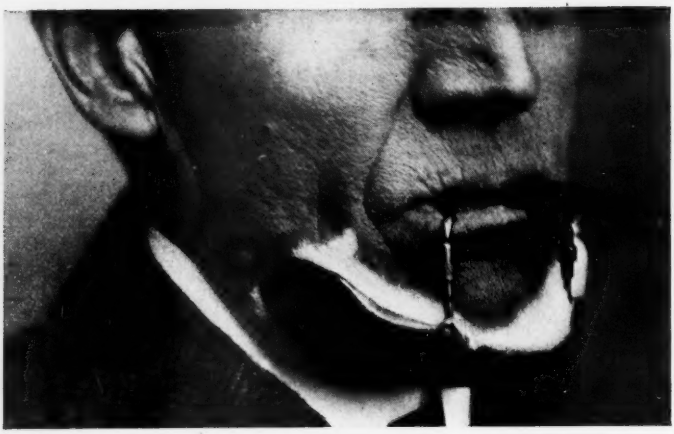


Fig. 2

I believe every hospital in the world, and every oral surgeon too, would be glad to have a set. Let a set comprise Splints Nos. 1, 2 and 3, one box modelling composition, three impression trays, and one box plaster of Paris, and a circular of instruction.

After you have taken the impression and have gotten your model to right articulation, burnish a piece of foil over model, then fill tray No. 1 with cement and hold on model till set; then remove tray from model.

It is now ready to be adjusted in the patient's mouth as shown in Fig. 2. Have chin plate ready fitted with gauze for compound.

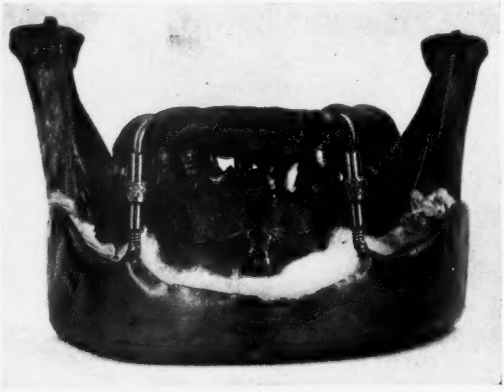


Fig. 3

Tighten screws snug, and there you are, and if your patient can't smile at the chap with an interdental splint or ligated jaw, I miss my guess.

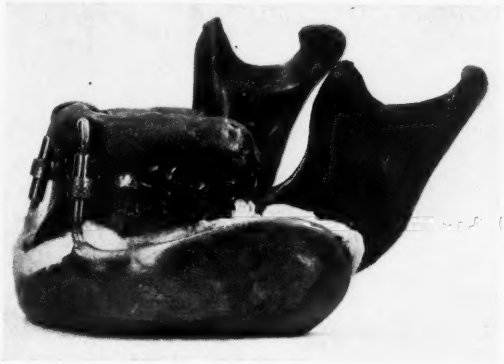


Fig. 4

Figures 3 and 4 show front and side views of the Vanderbilt Splint in position on a mandible.

If some of my good brothers can use the Vanderbilt Splint and like it, I will be glad and so will their patients.

(c) Times Wide World Photos

COL. ROBERT T. OLIVER DECORATED BY THE FRENCH GOVERNMENT

On August 28, 1922, General Pershing bestowed on Col. Robert Todd Oliver, as the Chief of the Dental Corps, U. S. A., the Cross of the Legion of Honor, in behalf of the French Government, as a token of the high esteem in which that Government holds the contributions of service by American army dentists to the cause for which France and America fought.

In response to a notice that this picture was to appear here, and an invitation to say a few words to the dental profession in connection with his decoration of Col. Oliver, General Pershing has sent the cordial and complimentary letter reproduced on the opposite page. This is framed in the Editor's office, where he will be pleased to have all dentists inspect it who care to do so.

—The Editor.

GENERAL OF THE ARMIES
WASHINGTON

August 25, 1922.

Dr. George Wood Clapp,
Editor The Dental Digest,
New York, N. Y.

Dear Dr. Clapp:

Your cordial letter of the seventh affords me the opportunity of a few personal words in appreciation of the splendid and patriotic services rendered by the American dental surgeons in the World War. Everyone of this generation realizes the intimate relation between good teeth and good health. The dental surgeons of the Army were most diligent and efficient in this respect throughout the military forces. But in addition, and that which ever will be regarded an outstanding service rendered by their profession, was the work of dental reconstruction among the wounded. Nor can I pass without commenting most favorably on their patriotism and devotion to duty at all times.

With all good wishes, believe me

Sincerely yours,

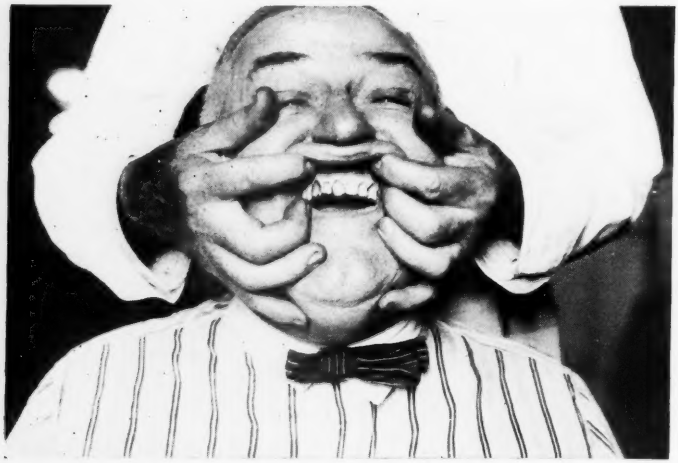
John J. Pershing

The New Wheeler Crown

By Edythe H. Browne, New York, N. Y.

Dr. Henry L. Wheeler of New York City has made a valuable discovery in the field of mechanical dentistry. Heretofore an all-gold crown or an all-porcelain crown was generally accepted as the usual restoration in prosthesis. Now after months of intermittent experimentation, first by soldering a rim to the ordinary gold crown, then building up the face of the crown with wax and casting the rim to secure the porcelain face, Dr. Wheeler brings out a combination crown of porcelain face and gold, and calls it an "aesthetic" crown, because it beautifies the tooth as well as preserves it.

This new type of crown has many very distinct advantages over the crowns formerly used. It affords the means of saving the tooth



without devitalizing the pulp. Teeth that are particularly short can be restored to original length by the new crown for a better bite instead of the old method of lengthening from the back by a plate. It is of greater strength than the jacket crown or any other porcelain crown. It can be used to great advantage where the posterior teeth have been removed to restore the six anterior teeth when worn almost to the gums. It can be used in any place where formerly an all-gold crown has been used.

Another advantage which Dr. Wheeler thinks might be applicable to country dentists who do not find ready convenience for baking the

porcelain is that his crown can be faced with silicate cement as well as with the baked porcelain.

Dr. Wheeler has applied his crown device to many of his patients with very favorable results, especially as the crown is in keeping with the present vogue in dentistry, of showing as little gold as possible.

The Wheeler porcelain-faced gold crown then is a product of Dr. Wheeler's laboratory experiments, and its technique may be briefly summed up as follows:

First, the teeth are separated from those adjoining by a safety side disc. Second, the occlusion, or biting surface of the tooth, is trimmed just enough to receive 30-gage gold. Third, the labial surface is trimmed with sufficient care so as not to endanger the life of the pulp. Fourth, the impression is then taken in plaster and a metal model is made of the tooth. The gold shell is then struck up on the prepared model and fitted to the tooth. The fitted shell is then contoured with inlay wax and carefully carved out to form a rim all around the edge of the labial surface. It is then invested and cast, and the crown is ready to receive the porcelain or synthetic enamel. If the porcelain face is used an impression of the crown is taken just as for an ordinary porcelain inlay and the facing cemented in.

19 East 89th Street.

An Interesting Case

By G. W. Bledsoe, D.D.S., Cullman, Ala.

The following case was referred to me for treatment, and a brief history of same is as follows: This patient's home was in the State of Mexico, and she was visiting her mother here at the time. For a number of years she had been suffering from epileptic fits, and her mother thought her family physician might find a cause, and this physician referred her to me to find if there was a possibility of a third molar impaction. The first examination eliminated that question. I found the four upper central incisors contained Richmond crowns; the two cuspids were normal; the upper left first bicuspids contained gold crowns, and the second molar contained a gold crown with a bridge swung thereon, with the same kind of bridge on the other side of the mouth.

This lady was about 30 years of age, very intelligent, but extremely nervous. She had been subject to epilepsy for seven years, and the work above referred to had been placed therein twelve years previous. She had spent quite a bit of time and money trying to find some cure, and had consulted specialists in large cities, who insisted that she have her teeth removed, but two dentists refused to remove them on account of the

prominence of her upper arch. When she smiled she would not only show her teeth, but also all her gums, and these dentists told her that they could not remove her teeth and make a denture that would look at all natural, and as they were not sure that her own teeth had anything to do with her physical condition she would not agree to having them removed. At the time she consulted me she had not been to see a competent dentist for two years.

I made a radiograph of the entire mouth and found that three of the incisors contained granulomas; both the teeth containing the bridge in the upper right had pulps removed, but I could not find any well-defined granulomas.

The teeth containing the bridge on the upper left were very badly affected by pyorrhea. I suggested at once that all upper teeth be removed, and she raised the objection which I previously referred to that her looks would be ruined and that in addition to that she was to visit in Birmingham, Ala., and also in Kentucky and return home in three months. Then I explained to her that dentistry had progressed some in two years, and I explained further that she needed a complete alviselectine. First, to please her and give the proper esthetic effect with the denture when made; second, in order that the denture could be completed while she was here and that she might make her visits before returning to New Mexico, and third, and most important of all, that by surgically removing the hard plate of bone that I might have a clear view of the granulomas in order to remove them intact. This was done, and I found that the granulomas were larger than the radiograph had shown. The wound was sutured up with a continuous suture. The patient went home with instructions to use ice-pack on the outside and use strong salt water on inside of mouth.

Eight or ten days later she reported with a mouth apparently well, never having reported to my office for any after-treatment whatever; however, I did not make the upper denture until a month later.

Shortly after I removed a lower right bicuspid surgically and also removed a large granuloma. Please understand that in all this work I did not use a drain anywhere, but sutured everything immediately.

The patient made the visits referred to above and reported back to my office in about a month, and had gained 20 pounds, and left for the State of New Mexico feeling like a new woman. Christmas we received a card from her and her husband, with a letter saying that she was well and happy and how glad her husband was that the work had been done, because he didn't know anything about it until she returned home.

I used Trubyte Teeth in making the denture, and did not make them quite as prominent as her permanent teeth had been. I agreed with a number of her friends who knew of this work that she looked better with the new denture than with her natural teeth.

Is It Exoneration?

Bearing of Recent Diagnosis Upon Dentistry

By L. C. O'Donnell, D.D.S., Greenville, Ohio

It is the desire of the writer to call the attention of the Dental Fraternity to a new diagnosis of disease, and to request their investigation of certain conditions now being brought to light which affect us both personally and professionally.

Years ago members of our profession were of the opinion that pyorrhea was of syphilitic origin, and since then we have discovered the pyorrhea expert, but today we are still at sea, and now Dr. Hartzell shows how, by thorough cleaning of the teeth, we can control the disease. Then we have the diet entering as a factor in the control and causation of this disease.

We are informed that malocclusion, defective fillings, bridges, etc., are causes, and these take us back to the uncleanly condition and we are again no further than before, for we have a recurrence of our trouble whenever the patient becomes careless and the mouth is neglected.

When we endeavor to create a condition of the mouth and teeth rendering them fool proof, or self cleansing, we manage to hold the pyorrhea in check, but beyond this point we have not been able to make any progress toward the eradication of the disease.

In this connection it is desired to quote a rather peculiar remark that was made by a patient, which was, "I have eyes and ears and they do not need care, why should I need to care for the teeth?" To some extent this is logical and again it is not. We have become civilized or uncivilized in our habits of life and we must counteract these conditions by other means, but should the teeth need this attention to the extent that apparently is necessary today?

Is there not some underlying cause for our troubles that we have not as yet learned? Why do we develop pyorrhea, why is it so stubborn, and why is it gaining ground, and we as dentists failing to keep pace with it by finding some cure? Are we only checking the cases as they appear and making but little headway? Something is wrong somewhere, but what is it?

Now we are informed by Dr. Abrams that the race has been impregnated with bovine syphilis through the medium of vaccination, and that almost all of us are carrying a high ohmage of this in our systems. It is also stated that pyorrhea responds or clears up when the syphilis is eradicated from the system, for the body has been cleansed of the soil necessary to develop pyorrhea.

Will this account for the former idea of syphilis being the cause of

pyorrhea and the increase of the disease being due to the increase of vaccination, or the impregnation of the people with the bovine lues?

Another feature of the Abrams' diagnosis is that streptococci infection is more general than we have supposed, and this will account for the failure of various cases to respond to extraction. This would appear to lessen the cases of local infection, for we have a general infection and the teeth in some instances may be the foci of increased infection, and their extraction would lessen the amount of general infection, thereby improving conditions temporarily. A case of focal infection would be rare, and so we can account for some of our problems.

This would not exonerate us from all blame, as poor canal fillings, etc., will increase the general infection and lower the resistance of the patient so that other conditions might arise. If, however, the general infection by strep. should be cleared up, would faulty canal work be much of a factor in disease? This may account for some past conditions also, for the older men in the profession have not always experienced the conditions that exist today.

Has not vaccination also infected us with strep. infection? What causes the swollen arm when vaccination takes? We know more about the "taking" than the laity, and the "taking" is the strep. infection.

Another case of diagnosis is desired to be considered, and that is our friend Trench mouth, Vincent's Angina, etc. The writer has heard of numerous blood tests being made for these without any results, but the Abrams method has shown the reaction.

A blood specimen was sent to Dr. A. L. McGowan, of Dayton, Ohio, of a case of Trench mouth and he found the vibratory rate of acquired syphilis. Another specimen taken at the same time and from same patient was tested by Dr. H. J. Pierce of Greenville, Ohio, in the presence of the writer, and this showed the same result. It is unfortunate that the ohmage was not measured but this will be done later.

A man who had been treated for Trench mouth about three or four months ago submitted to the taking of a blood specimen which was tested and showed same result as others, and the ohmage was seven. This last test was not under favorable conditions and will be made again to insure accuracy for future data.

Now the question arises can we be infected by syphilis without any more evidence than in Trench mouth, and does it remain in our systems as does the bovine lues? Can we have an infection of this disease which has in the past eluded our endeavors to show it by the tests we have been using?

If these vibratory rates of diseases show to us new conditions and open up new lines of advancement will the dental profession be exonerated from some of the blame that the medical profession has been attaching to us, and will this act as a boomerang and return to them?

If these methods are correct we have been laboring under misrepresentations and will be able to make an advance on pyorrhea that we have not been able to in the past.

The use of the osciloclast in these cases may show us how the system may be cleared of conditions heretofore unknown, and it will be well for the dental profession to watch closely the results of these various cases as our future advancement as a profession may be determined, and we should be thoroughly conversant with this method.

Dr. Abrams, a physician, may be the man to exonerate us, and from all that has been seen by the writer in following the diagnosis and treatment, it appears that this is a marvelous discovery, and a revolution in medical treatment is impending.

Death of Dr. Boardman

Dr. Waldo Elias Boardman, who died at the Nebraska Methodist Hospital, Omaha, Nebraska, August 14, 1922, when returning from the meeting of the American Dental Association held at Los Angeles, California, was born in Saco, Maine, September 1, 1851. He descended originally from the Boardman family of Cambridge, England, who settled in Cambridge, Mass., in 1600. On his mother's side, Dr. Boardman descended from Captain Jonathan Poole, a noted Indian fighter.

Dr. Boardman received his early education in the public schools of his native city and in the Bryant and Stratton Business College, at Portland, Maine. He first engaged in the boot and shoe business with his father, in Saco, in 1869. In 1871 he came to Boston and was a patent solicitor, in connection with patent cases, for nearly seven years, when his health failed owing to overwork. After some years' rest, he engaged in the newspaper business in New York City and the publication of a weekly trade journal devoted to the cotton belt. After a year's experience in the newspaper business, he entered the dental department of Harvard University in 1883, and completing a three years' course, was graduated from that institution June 29, 1886. He at once became an instructor in operative dentistry, and filled that position for ten years. He also became a member of the administrative board of the dental college in 1889.

Dr. Boardman's practice was confined to Boston, except for a time in Bristol, England, in 1899. He was Curator of the dental museum of Harvard University from 1899 until the time of his death, and from a small nucleus built up a library of over three thousand volumes.

Dr. Boardman held practically every office in the gift of the members of the various dental organizations in Boston and Massachusetts. No man in the history of dentistry in Massachusetts has been as active as was Dr. Boardman, or has carried the burden of the executive business of the various societies so many years, or filled the positions as acceptably as did he. He was a member of the organizing committee of the Fourth International Dental Congress held in St. Louis in 1904; president of the National Dental Association in 1904-5; a member of the International Dental Federation, and various other dental organizations. He was a member of the Boston Art Club, the City Club of Boston, and a life member of the Massachusetts Sons of the American Revolution. He was a member of the Board of Managers of the last named organization for some years, and a delegate at National meetings of these organizations.

Dr. Boardman was a frequent contributor to dental periodicals and read many papers before dental societies. There is probably no member of the profession in recent years who has devoted so much of his time to the management of dental society affairs as did he. For over twenty years he was a member of the Executive Council and a trustee of the National Dental Association, and at the recent Los Angeles meeting he was elected a trustee of the American Dental Association for three years.

No man could have been more faithful and loyal to the interests of his profession than was Dr. Boardman. He ranked high as a business man and had executive ability of a very high order, which was freely given for the benefit of the organizations with which he was connected. He was a man of high-toned and splendid ideals, and was always ready to do his utmost for the uplifting and advancement of his profession. He was true, honest, loyal, and conscientious, and his word was as good as any man's bond. He was always frank and open in the consideration and discussion of any question, and endeavored to work for the best interests of his profession. He was many times plain spoken and direct in his conversation, but always tried to put aside personal consideration in the discussion of the various questions that came up for decision. He was of a most kindly and generous nature, and a fine companionable fellow.

There are few men in the profession who enjoyed as wide an acquaintance as did Dr. Boardman, or who had so many loyal and devoted friends. He will be greatly missed by the members of the various organizations to which he belonged, and nowhere more than in the dental societies in his own state, where he gave so much of his time and substance. The dental profession everywhere is indebted to him, and his passing away will bring regret and sorrow to his friends throughout the world.

Ethics

By C. A. Roberts, D.D.S., Brownsdale, Minn.

The dictionary gives two definitions of the word ethics, each worthy of consideration. First, "The science of human duty." Second, "The basic principles of right action."

I do not believe there is a man who has attained the degree of Doctor of Dental Surgery who can fail to sense the obligation laid upon him by the first definition. The second definition, however, seems to leave a large field for consideration. It seems to me that we search for the basic principle and subdivide this one principle to meet the various causes and effects.

It should be our aim to do our work so that it will give the greatest service to our patients regardless of cost. This then is the basic principle.

Having given you the definition of ethics as I understand the word, I shall try to tell you a little of my beginning a professional career. I will tell you of a few of the problems that I had to work out, some of the failures, and some of the successes.

I began my career as a public dentist in 1908, and my false conception of ethics at that time greatly handicapped me. I was graduated from one of the best Dental Schools in the country and felt that I was well equipped, theoretically at least, to begin practice. Each patient was examined and treated to the best of my ability with the intent to make each one a booster. I had my fair share of patients and received good fees for my services, yet at the end of the year when the ledger was balanced I had little left on the right side. This continued for four years, when I concluded to investigate some of the so-called Dental Parlors. These so-called Parlors were then advertising 22kt. gold crowns for $3.00. I was getting $10.00 for mine.

You may ask why, if I had my share of patients and was receiving good fees, I sought a change. Some of the trials I had to undergo and problems I faced were probably not so different from the average beginner in the profession. I shall tell you of a few of them, which will explain why I wanted a change. I had lots of time on my hands that was not productive, and I wanted to find out how to pack the office with patients at least during business hours.

If you have carefully adjusted the rubber dam and carefully prepared a step cavity in say a lower first molar, followed out Black's extension for prevention, etc., used the separator, had the patient return for a final sitting and then carefully polished the restoration, and then had her return within a short time with one of the walls slivered off, you will recall how much explaining was necessary and how incompetent you felt at heart. Perhaps the walls were strong

enough to stand, and although you had previously explored the cavity for possible exposure of a pulp horn, patient returned and complained of thermal shock. Perhaps she didn't return at all until the pulp died and then came in with a swollen face and an extremely worried countenance—blood poison sure. The patient knows it's blood poison and that you with your instruments which she is sure were not clean, infected her. Didn't Mrs. Jones' husband's sister's child have one just like it, and didn't she die? If you are fortunate enough to escape a law suit, there yet remains the fact that your work and your best efforts failed.

Let us suppose that you found an exposure in this same tooth and decided to destroy the pulp. After many visits and hours of conscientious work, you filled the roots, then anxiously awaited results. You were not disappointed in the majority of cases if your patient came back with apical trouble, in fact you rather expected this to occur. Having the patient's welfare at heart you probably opened again into the roots and after exhaustive treatment again filled them and dismissed the patient with a prayer in your heart that something would happen to either of you that would prevent her calling on you again. If you haven't had this sort of trouble, it's dollars to doughnuts you didn't stay in one location long or your patient went elsewhere for further relief.

Another nice thing for the young practitioner to have to contemplate each day is the extraction bug bear. How many of you were even fairly skilled in this branch when you left school? How adept were you in the art of administering a hypodermic? Or did you ever have any experience with a nice case of cocain poisoning? In the average private practice how long do you think you would have to live to have sufficient patients to practise on and become proficient in these little things. In the mean time securing enough money to meet current expenses?

There are many who take up the study of dentistry who are financially able to meet living expenses, etc., but on the other hand, there is that class who are forced to depend on each day's receipts. It has been taught and the impression given us that money should be about the last consideration. This Utopian dream is all right as theory, but it has been my experience that it is far from practical.

With such troubles as the foregoing to overcome I decided to investigate some of the large advertising parlors and secured a position as operator at a salary of $36.00 per week. In addition to this we had a sliding scale of commissions, viz., if I did $150.00 worth of business in one week I received an additional $2.50; if I did $200.00 I received $9.00 additional, and for every dollar above $200.00 I received 15%.

This is very bad business as far as results for the general public is concerned, and of which I shall speak later.

I learned a number of things in this institution that if I ever knew I had forgotten all about. One very important thing was that time was money and each moment is made productive. At this place we had one man who was examiner and contractor. When a patient called he examined him and charted the work to be done on a regular record card. The price was also fixed by this same contractor. The patient was assigned to some operator, card handed to him and the work begun. If the case was one of bridgework, it was the operator's duty to prepare the teeth, make the abutments, take a wax bite and plaster impression. A maid was at hand who whisked the case to the laboratory department and returned it finished in what to me then was an incredibly short time. Then the operator cemented on the bridge, collected the fee and was ready for number two. This procedure kept up from 8.30 A. M. to 8.00 P. M., with an hour off at noon for lunch. Cleanliness and neatness were given much attention at this place and a corps of maids were kept busy sterilizing instruments and replacing soiled linen, etc. Every facility for keeping clean was at hand and insisted upon. I may also state here that this particular company never advertised anything it did not do, and the guarantee was unconditional, absolutely. If a patient returned, his record card was produced and if any work was not absolutely satisfactory it was remade or adjusted without charge.

To those in the profession who can cater to the elect of the laity, perhaps this article will not be of much interest, but if they conclude to serve that mass of worthy humanity, the common people, then they must consider those things that appeal to the common people. They must reduce their language to terms in common use by that class of people. They must conduct their business contracts in a manner understood by the party with whom they are trying to make that contract. This does not have a very professional aspect, it is true, and smacks of commercialism but it is necessary and if conducted from a truthful standpoint there is no good reason why it should not be done. Among the great mass of people with whom we have to deal, I find only a small percentage of them have even an eighth-grade education. It requires some little tact to meet them on their own plane, as it were, and yet reserve that amount of dignity essential to maintain your professional position.

If you have placed restorations for people such as these, and they have failed time after time, it is hard to convince them that dentistry is a success, and that dentistry that lasts can be done. If you doubt this statement refer to your records and ascertain how many patients that you served four years ago have returned for examination or further

work. All the general public cares about at present is how much will it hurt and how long will it last. When you can assure them that their work will last at least a reasonable length of time, and that it can be done with little or no pain, the question of fees can be left out entirely. You can practically demand your own price. Low price at the present time will attract them and enable you to get out a volume of work that will speak for itself. It will bring greater numbers of people to the dental chair that now avoid it. When this has been accomplished the fee question will care for itself.

This class of people are very negligent about brushing their teeth, and while our constant hammering has its good effect, for many years to come it will be necessary to do dental work of a class that will stand this negligence and abuse. For instance, if you have a tooth that needs a filling, say of alloy, why not clean that cavity thoroughly, protect the pulp with some non-conductive cavity lining, and construct a good-fitting gold crown? As a certain flour manufacturer once said, "Eventually, why not now?"

There has been much said about the evils of the gold crown, but it is my opinion that when properly constructed and fitted they give the most service of any restoration. One all important organ to be considered when using the gold crown is the peridental membrane. In fitting the band too much care cannot be exercised trimming it so it will not impinge upon this membrane at any point. The fitting of bands is a very delicate operation, and for the careless or dishonest operator it is a loophole of large dimensions.

Personally I do not believe in devitalized teeth. I have been in a position where I have had the opportunity to see the come-backs of other dentists for years. I have spent many weary hours digging away at obscure canals and I am of the opinion that I never placed a perfect root filling. I have noticed the peculiar change in the structure of the enamel of a devitalized tooth, especially one that has been so for a long time. This I think due to the destruction of the protoplasmic cavities situated at the dento-enamel junction, thus failing to supply the nutrient plasma to the enamel. The enamel becomes brittle and if the rods are somewhat parallel, splits off with little resistance. Also the peridental membrane does not seem to get the proper nourishment, or at least the nutrition is disturbed and we have a point of lowered resistance to germ invasion, even if the tooth apparently gives no local trouble.

Referring again to the commission form of payment for operators employed by these large dental concerns, I know it to be wrong, because it is so easy to slip up on a little extra preparation and care, when one is confronted with that 15%. If one happens to badly need the

money, and the only chance for securing it is to get out a certain amount of work, it's a safe bet that the work goes out. Too great a temptation exists to sacrifice quality for quantity.

Now again comes the question of ethics. I serve the public and my fellow man to the best of my ability. I plan out his dental needs to the end that the work shall last as long as it is possible for me to make it, and at the same time be no source of systemic infection to him. I back up this work with an honest guarantee. I have no way of telling him these things except through the medium of the press and I pay for my advertising space. I never advertise the impossible, in other words, I live up to my advertisements. I never knock my brother practitioner, but often disagree with him in matters of diagnosis. If ethics is the basic principle of right action I contend that I am ethical.

The Use of Heat in Anesthesia

There is no question as to the advantage of administering the anesthetic gases and vapors *warm* rather than cold. A concentrated ether vapor air mixture which is readily inspired at a temperature of 95° Fahrenheit may be practically irrespirable at 45° Fahrenheit by one who is conscious. With the usual methods of etherization, heat is supplied by the expired air to a degree depending upon the amount of rebreathing. With the open drop method, the temperature under the mask varies from 41° to 68° Fahrenheit. With an open cone seven inches in height, the temperature within the cone is between 84° and 90° Fahrenheit, at a room temperature of 76° Fahrenheit. The application of heat to anesthetic vapors and gases which are to be transmitted to the patient through tubing, is generally so inefficient that the only effect is upon the mental state of the anesthetist. This may readily be shown with an ether vaporizer, a length of tubing, and a thermometer. With a room temperature of 72° Fahrenheit a flow of ether vapor and air at 10 liters a minute and a tube ¼ inch in diameter and four feet long, a mixture at a temperature of 32° Fahrenheit as it comes from the vaporizer, becomes heated to 71° Fahrenheit in passing through the tube. If the tube be held in the hand, the same mixture emerges from the tube at a temperature higher than the room temperature. Because of the low specific heat of gases, they tend to rapidly assume the temperature of the room and the usual methods of heating them for anesthetic purposes are unnecessary and useless.

—*From Current Researches in Anesthesia and Analgesia.*

Report of Committee on Dental Nomenclature*

By L. P. Anthony, D.D.S., Chairman, Philadelphia, Pennsylvania

(Presented to House of Delegates, National Dental Association, Los Angeles, Calif., July 17-21, 1922)

YOUR committee begs to report as follows: The purpose of the nomenclature of dentistry as of any profession is to provide the means for the intelligible interchange of ideas to the end that its development and growth may progress and keep pace with that of the other professions.

Through its literature each profession becomes acquainted with the state of development of its sister professions and thereby is judged as to its intellectual status and the verity of its accomplishments. The scientific status, the exactness of knowledge, the cultural developments and the mental habits of a profession are distinctly reflected in its literature, and the retarding influence of insufficient and defective vehicles of expression must be removed if it is to keep pace with the other learned professions.

We are all conscious of the fact that the development of dentistry for the past two decades has been moving forward with such rapid strides that our present terminology no longer meets the demands of the science and imposes a serious handicap upon our progress that we can ill afford to longer ignore.

The expansion of the field of dental activities resulting from the general recognition of the interrelationships of oral infections and bodily disease has necessitated an equivalent increase in our descriptive nomenclature. In response to this need for a larger terminology we have unfortunately been flooded with a group of terms that are manifestly amateurish in conception and defective in their etymology, hence they fail to correctly function as descriptive designations.

It is quite apparent that the busy practitioner is indifferent to this important phase of our literature, seemingly being content with and almost demanding that the subject be dealt with by those intimately concerned with the historical record of dentistry in the literature—namely, teachers, writers, editors, etc., they being in a better position to undertake the task involved in the harmonizing of our present terminology and enlarging it to meet our requirements.

Since the notable efforts of Black, Guilford, Molyneaux, Wilson and others at the time of the World's Columbian Dental Congress, and later those of the American Institute of Dental Teachers, little has been done to increase and enlarge our nomenclature, with the exception of some

* This report will be published in the *Transactions of the American Dental Association*, held in Los Angeles, California, 1922.

individual efforts. Individual efforts, while they may be praiseworthy and often productive of much good, inevitably lead to confusion in the use of several words to mean the same thing, and mainly serve to impress more forcibly the necessity for coordination of efforts to the desired end.

Any effort, however, to standardize our nomenclature should be made with a definite purpose of conforming it as closely as possible to the general laws of nomenclature as already accepted by the biological sciences. The desirability of this course needs only to be mentioned here; so also is it only necessary to suggest the resulting enormous saving of duplication of work in the elemental phase of the undertaking that would accrue from this course.

There is a two-fold responsibility involved in the adoption of a scientific dental terminology. Terms must not only express their meaning with precision, but as in medicine many terms are used to express a relation to a pathological or other biological phenomenon. These terms must not only be correct in an etymological sense; they must be so coined as to have a correct scientific meaning, and those who originate them must not only possess the cultural fundamentals necessary to constructive work in the science of nomenclature, but must also have a broad scientific vision, as well as an intimate knowledge of the subject in all its aspects.

Realizing the desirability of coordinating the various efforts being made to bring about uniformity of dental terms and conscious of the necessity for a distinct forward step in the field of dental nomenclature, the Dental Editors' Club, an organization composed of the editors of dental magazines of the United States and Canada, at its meeting in Milwaukee passed the following resolution:

> WHEREAS, the Dental Editors' Club of North America at its meeting in Milwaukee, August 17, 1921, realizes the pressing need for standardization of dental terms, be it
>
> *Resolved,* That the Dental Editors' Club of North America petition the House of Delegates of the National Dental Association to appoint a standing committee on nomenclature, to whom matters relating thereto emanating from various committees on nomenclature of other organizations be referred for consideration to the end that the standardization and harmonizing of our technical dental terms may be under the direction and control of our national organization.

Pursuant to the intents and purposes of the above resolution, the National Dental Association appointed the following committee on Dental Nomenclature: Drs. C. N. Johnson, Otto U. King, H. E. Friesell, H. L. Wheeler and L. P. Anthony, as chairman.

Soon after the adjournment of the Milwaukee meeting, the chairman of the committee took steps to get in close touch with those who have shown interest in this phase of dentistry with the result that many suggestions from individual members of the profession were offered as to the adoption of new words and many criticisms made upon words now in use. We also have had the cooperation of several subordinate organizations of the National who have suggested words relating particularly to the specialties with which they are concerned.

The committee, while feeling the necessity of prompt action in regard to some of the words and suggestions offered, does not feel that it can present a final and definite report on all the terms that have been considered at this time.

It is not an easy task to decide upon the adoption of a certain class of words in dental nomenclature, as the conditions are continually changing and it is practically impossible in some instances to foresee all the difficulties that may subsequently arise in the use of a word.

As an example one word will suffice. All are familiar with the long drawn out discussion of the use of the words "model" and "cast." After so many years the profession has about accepted the word "cast" as preferable to "model," as the word "model" is incorrect in the sense in which it has been so long used in dental literature. Now that "cast" has been accepted, the development of the method of inlay casting has much confused the use of the word "cast" so that now it is quite difficult in some instances to apply the word generally.

There is also much unforeseen difficulty in other phases of dental literature, namely, conforming our nomenclature to that of the other biologic sciences. We cannot afford to disregard the nomenclature of other sciences in forming our own, and, while there are instances in which we have by determined effort succeeded in establishing the use of some words which have conflicted with their use in other sciences, we do not feel that it is worth the effort and the resulting confusion consequent thereto. As examples of the latter, we might cite such words as "articulate," "cuspid," "bicuspid," "mandible," etc. In the case of the last mentioned word it has caused much confusion in anatomical nomenclature for the reason that the nomenclature of the teeth, jaws and surrounding parts has been built around the word "maxillary" applied to both jaws, and the adaptation of mandible has been difficult and thus far not accomplished completely in relation to the anatomical term given to the parts contiguous to the mandible.

All of this may, however, be avoided if we keep to the suggestion in the forepart of this report, i. e., that our nomenclature be designed to conform to that of the other biologic sciences.

The objection is often raised to so-called hybrid words, i. e., words which have both Greek and Latin derivative root words. This occurs

to the committee as being more or less pedantic. The vast majority of the words of our language are of Greek and Latin origin, and such being the case there is no valid reason to the committee why, if the two languages are chosen and preferred as derivative languages, we should not avail ourselves of the advantages to be gained by a combination of the two in forming our words.

Generalities with regard to nomenclature, its purposes and the best methods of deciding upon terms are all well and good as suggesting principles upon which to work, but we realize that what is most desired particularly is some concrete result reached by the committee. We have therefore and with careful deliberation prepared a list of words which we recommend to the association for adoption and use in the sense in which we suggest they should be used. We also present some words suggested which do not seem to conform to the intents and purposes of dental nomenclature, and which we recommend be abandoned as promptly as possible.

List of Words Recommended

alveolectomy (L. alveolus + Gr. ektome, excision). Excision of a portion of the alveolar process.

alveolotomy (L. alveolus, [process] + Gr. tome, cut). Incision into the alveolus of a tooth, as for locating the end of a root of a tooth.

anesthesia. Preferable to anaesthesia.

apicoectomy (L. apex, gen, apices, the end [of a tooth root] + Gr. ektome, excision). The operation of excising the end of the root of a tooth. To be used in preference to apectomy; apiectomy; apicectomy.

artificial denture. Preferable to plate.

cuspid. In preference to canine.

cementum. To be used in preference to cement.

conduction (adj.). To be used in preference to conductive, as in conduction anesthesia.

deciduous (adj.). To be used as designating the teeth of the first dentition, in preference to the terms "temporary," "milk" or "baby."

dentural (adj.) (L. dens, dentis, tooth). Relating to the denture.

first molar. To be used in preference to "six-year molar," "sixth-year molar."

mandible (L. mandibula from mandere, to chew). The lower jaw.

maxilla, pl. maxillae (L. maxilla, jaw). The upper jaw.

morsal and occlusal (adj.). To be used synonymously as relating to the masticating surfaces of the bicuspid and molar teeth.

centric occlusion. To be used to express the relation of the inclined planes of the teeth when the jaws are closed in the position of rest.

eccentric occlusion. To be used to express the relation of the inclined planes of the teeth in the excursive movements of the mandible.

mesial and distal. These terms as used today have been objected to as not being in conformity with anatomical nomenclature, where they are used to indicate relation to the median line of the body. They have, however, become so fixed in dental nomenclature that we do not suggest any change.

pathodontia (Gr. pathos, disease + odous, tooth). That branch of dentistry which has for its purpose the study and treatment of diseases of the teeth.

pathology (Gr. pathos, disease + logos, treatise). That branch of medical science which treats of morbid conditions, their causes, symptoms, etc. This term is being loosely used to indicate a disease or pathologic condition, which is confusing, unnecessary and undesirable.

pediadontia (Gr. pais, paidos, child + odous, tooth). That branch of dentistry which has for its purpose the study and treatment of children's teeth and mouth conditions.

periodontia (Gr. peri, around, + odous, tooth). That branch of dentistry which has for its purpose the study and treatment of diseases occurring around the teeth and their roots.

periodontal (Gr. peri, around, + odous, tooth). Relating to the alveolo-dental ligament. To be used in preference to peridental.

periodontoclasia (Gr. peri, around + odous, tooth, + klassis, breaking [down]). The destructive degeneration of the tissues about the root of a tooth. Substituted for pyorrhea alveolaris; Riggs' disease; interstitial gingivitis.

periclasia (Gr. peri, around, + klassis, breaking [down]). Used as a shortening for convenience of periodontoclasia. Should be used with a qualifying word, as in itself it does not mean anything in particular.

pontic (L. pons, pontis, a bridge). (Adj. and noun.) A substitute for a natural tooth. Used in preference to dummy.

bicuspid. In preference to premolar.

prosthesis (n.) (Gr. pros, to, + tithemi, to place). Preferable to prothesis. (Because of the more definite application of the Greek preposition pros, as compared to pro in this form).

prosthetics (n.). Preferable to prothetics. (For same reason as in prosthesis.)

pulpless tooth. To be used in preference to "dead tooth," "devital tooth," "devitalized tooth." In cases where there is a "vital " pulp in a tooth or a "non-vital" pulp, it should be so designated; e.g., a tooth with a vital pulp, or a tooth with a non-vital pulp.

radiology (n.) (L. radius, ray + Gr. logos, treatise). The science of radiant energy. To be used as the generic term to indicate radiant energy from whatever source.

radiogram (n.) (L. radius, ray, + Gr. gramma, a writing). The product or tangible result, as the film or the print thereof, of the radiographic process, actuated by radiant energy of whatever source.

radiograph (verb) (L. radius, ray, + graphein, to write). The act or process of making a radiogram.

radiography. The art of making radiograms.

radiopaque (L. radius, ray, + opacus, shady). Term applied to a substance that is impermeable to the various forms of radiant energy.

radiolucent (L. radius, ray + lucere, to shine). Term applied to substances that allow the passage of radiant energy light, but offer some resistance.

radioparent (L. radius, ray + parere, to appear). Term applied to substances that freely transmit the light of radiant energy.

roentgen ray. To be used in preference to X-ray, and only where the specific ray is indicated.

roentgenology. The study and use of the Roentgen ray in its application to medicine and dentistry.

roentgenography. The art of making roentgenograms.

roentgenogram. The shadow picture produced by the Roentgen ray on a sensitized film, or the print from the film.

roentgenograph (v). The act of making a roentgenogram.

second molar. To be used in preference to "twelve-year molar," or "twelfth-year molar."

third molar. To be used in preference to "wisdom tooth."

Vincent's infection. To be used to express the ulcero-membranous stomatitis caused by Vincent's spirilium and fusi-form Bacillus; in preference to Vincent's angina; the latter being more applicable to the throat infection.

x-ray (n.). This word is used indiscriminately as a noun and verb. It should not be used as a verb. The word Roentgen ray is preferable. It should also be used with small x rather than with the capital X, if used at all.

penetology; odontalysis. These two words have been suggested, the first to mean the science of radiant energy, and the latter, examination of the teeth. We see no justification for these two words either etymologically or otherwise.

The committee is pleased to state that in the near future there will be available places of accessible record of the activities in the field of dental nomenclature that have not been open to the profession since the passing of Harris' Dental Dictionary. If the present plans mature as proposed there will soon be issued no less than three dictionaries devoted to dentistry, namely, one compiled by Dr. W. B. Dunning, under the auspices of the American Institute of Dental Teachers; one compiled under the direction of Dr. Louis Ottofy, of Chicago, and a third compiled by the chairman of this committee. The committee and the profession can thus feel assured of a permanent continuing record of its activities in the future.

In concluding the report your committee earnestly solicits the co-operation of committees on Nomenclature and of individuals who are actively interested in this subject, to the end that our nomenclature may be as expeditiously as possible enlarged to meet the needs of the profession.*

Respectfully submitted,

L. Pierce Anthony, *Chairman.*
C. N. Johnson,
Otto U. King,
H. E. Friesell,
H. L. Wheeler,

Committee.

* The House of Delegates by unanimous vote received, adopted and authorized the publication of this report.

DENTAL LAWS

Foreign Information

By Alphonso Irwin, D.D.S., Camden, N. J.

GREAT BRITAIN

The registration of dentists in England. The New Act provides that no person not registered may practise or hold himself out as a dentist in the United Kingdom.

Section 3 provides the manner in which applicants for registration are dealt with.

The Act, with respect to new comers in the practise of dentistry in the United Kingdom, does not essentially alter the long standing arrangements.

The new Dental Board described in the Act is not responsible for dental education in this country. The General Medical Council still has charge of this matter, and the Board registers persons possessing qualifications recognized by the Council.

The General Medical Council does not, at the present moment, recognize any American Universities, but it is open to these bodies to make an application for recognition. To do this, letters should be addressed to the Registrar of the General Medical Council, 44 Hallam Street, Portland Place, London, giving full information as to the course of study and examinations which the University provides, and the matter will, in due course, be brought before the Council. Hitherto the General Medical Council has usually considered that American Universities, from the British point of view, are deficient in regard to the general hospital work required in this country, and it is for this reason that recognition has not been accorded.

American practitioners not already established in this country, and who desire to practise dentistry therein, must satisfy the Examiners that they have carried on their studies for the full length of time required in the case of British students, and, further, must pass the usual final examinations.

SOUTH AFRICA

Southern Rhodesia, Union of South Africa Dental Ordinance dated 1900, amended 1913.

English language, Medical Council supervision and registration of dentists are required. The Ordinance states:

The persons following shall be admissible to practise as dentists in Southern Rhodesia and to obtain the requisite license so to practise.

(1) Every person duly admitted and lawfully entitled to practise in the Colony of the Cape of Good Hope as a dentist.

(2) Every person who is a licentiate in dental surgery or dentistry in the United Kingdom (of Great Britain), or in any British Colony or Possession.

(3) Every person who shows to the satisfaction of the Administrator that he is the holder of a certificate, diploma or other sufficient document, entitling him as the holder thereof to practise dentistry or dental surgery in any foreign country, and furnishing sufficient evidence of the possession of the requisite knowledge and skill for the efficient practise of dentistry or dental surgery.

(4) All dental diplomas registrable in Southern Rhodesia shall be required to cover a minimum curriculum of three years.

(5) Every person who, before the passing of this Ordinance, obtained admission or authority to practise as a dentist in Southern Rhodesia.

Registration fee 10 pounds (about $50.00 U. S. C.), payable to the Secretary of the Medical Board. Annual Tax 5 pounds, payable to Receiver of Revenue. Address for further details the Medical Director's Office, Salisbury, Rhodesia.

BURMA

This is a part of India. Consequently Burma is a British Colony. The Earl of Reading is the Governor-General.

There is no dental law. The dentist is required to take out a municipal license and pay the local taxes. Rangoon and Mandalay are the chief cities. The resources, particularly mineral (Ruby chiefly), of Burma are valuable. The people are Buddhists, fun-loving, intelligent Hindus. Buddhism is the principal religion. Hindus of the upper class are cultured. There is reported to be openings for dentists in the larger cities of India. There are one hundred and forty languages or dialects spoken in India. Sanskrit is the ancient language.

The population of Burma alone is over 12,000,000. The High Caste and European population patronize the professions most liberally. The great majority of the people are very poor. Acknowledgment of the customs, religion, habits and languages of Burma should be numbered amongst the qualifications of any foreign dentist contemplating the practise of dentistry in Burma.

HONDURAS, CENTRAL AMERICA

The following is part of a communication received from a practising physician in Honduras, regarding Dental Laws in this country:

"Nothing is said about the special treaty made between the U. S. A. and Central America regarding recognition of diplomas of reputable schools. You may have to get that from Washington, D. C. I have been told that it stipulated that Honduras would recognize diplomas but that they must be registered at the Capitol. There is no Dental Hygiene Act here.

"Should any American come to Honduras to practise dentistry, he should first learn from some American dentist in practice here, of the possible trouble he may encounter. There are some unwritten laws that one must not put in print, you understand."

TRANSLATION FROM THE SPANISH REGARDING DENTAL LAWS

Art. 323. Persons who have obtained the corresponding titles in other countries, may incorporate [matriculate] into the respective faculties to exercise their professions. Also recognition can be obtained for studies made in another Nation.

Art. 324. The incorporation and the recognition shall be effected [by] complying with the requisites stipulated for the case, in the treaties which the Republic has, or may have with other Nations.

Art. 325. When there are no treaties on incorporation [reciprocity] either [or], on recognition of studies, the party interested should present himself to the Rector and solicit through writing an examination, accompanying his title or documents duly legalized.

Art. 326. The solicitude [application] being petitioned [granted] the Rector shall order the necessary examination in the respective Faculty, or in the college of advanced studies, according to the grade in question.

Art. 327. The examinations of incorporation [credentials] and the consequent expedition registration of titles, are subjected to the rules and conditions prescribed in this Code with respect to scholars of Colleges and Faculties.

NOTE.—We have interpolated the words in brackets indicating the meaning more clearly, which the Honduras translator intended to convey apparently, in his English version of the Spanish Ordinance regulating the practise of dentistry in the Republic of Honduras.

DENTAL ECONOMICS

How the Advertiser Gets By

By George C. Drinkwater, Havre, Montana

The advertiser, to the dentist that does not feel himself marching under that banner, may represent a great many things, but casting aside all petty ideas concerning the other man's methods, and viewing his business with an unbiased mind, certain things stand out very prominently, one of them being the fact that he gets the money, and most of it is removed from the patient "painlessly."

Place yourself in a prospective patient's place, in your mind, and visit the office of the advertiser. The first thing that would be impressed on you, without any doubt in your mind whatever, would be that he would do a certain amount of work for you for a certain amount of money. The contractor would look over your mouth, and your name, address, and amount of work you need, or is impressed on you as needed, is put down on a card or blank—work sold to you for a definite amount, and you are then passed on to the operator (or expert?) in that line who can do your work. If your work should require several appointments, you are told so, and also you must make a deposit of a certain amount, that is recorded on your blank, if you must come back again for future work to complete your case, and you do not leave the office until work done is paid for, for the deposit you pay is equal or more, never less, than the amount of the work you had done at that time. Should your work be completed, you pay for all of it at that time.

Does not the fact of the definiteness of everything stand out? You get so much work or dental service for so much money; the situation is handled by the contractor, not the patient, and lest we forget, if you get the work done you pay for it then, not in the future. A dentist may not feel that he should sell his services in the same manner or by similar methods used by an advertiser, but people seem to like those methods, as they return to them for future work oftener than is generally supposed by outsiders.

Another feature that an advertiser brings out in his selling talk is the fact that he usually gives a definite guarantee for his work; quite

often it is used as part of the selling talk, and also used as a means of collection because the work or dental service is sold—guaranteed for a certain price.

When a patient asks a dentist how he guarantees his work it sometimes spoils the sale, because such a thing is immediately treated with scorn, but the same dentist might himself buy a certain article in preference to another, because it carried a certain specified guarantee. Most dentists handle that feature to suit themselves, but instead of holding the patient up to derision, it might be well sometimes to see if you do not yourself occasionally make such demands of other people. Examination of a written guarantee will generally reveal that no more is promised than any dentist does promise a patient, so far as service and usefulness of any restoration could be fairly considered, by both patient and dentist, as involved in the transaction or sale.

Collections

One very hard feature of the dental business or profession is the fact that accounts that a dentist feels he should get within a certain time are not paid, or evaded so successfully that the dentist himself gets nothing out of the transaction but experience and knowledge that he was beaten to it.

The best place to find out reasons why bills have to be collected would undoubtedly be from a collector. The reasons given by a collector for bad accounts are as follows:

1. Carelessness on the part of the dentist.
2. No definite understanding is reached between the patient and dentist when work is started.
3. Dishonesty of patient.
4. Fear on the part of the dentist.

These will be elaborated on in the order above named.

1. Carelessness on the part of the dentist from a collection standpoint would include not rendering statements promptly, the patients not being informed that they really have an obligation to fulfill; if you do not express it definitely yourself the patient may not do so.

2. Where no definite understanding is obtained at the starting of the patients' dental work, the patients may allow you to finish work, even when you try to and apparently obtain an understanding later; they have the work and you might find they consider the matter settled as far as they are concerned, and they may pay for it at their own convenience.

3. The dishonesty of the patient is brought to the dentist very vividly after he tries to collect his account and finds the person has the reputation of being a dead beat, and has nothing that can legally

be taken away from him, should such a thing be necessary. The patient appears to be immune, once he gets out of your office.

4. Fear on the part of the dentist in trying to collect an account. Collectors state that accounts that are hardest to collect are those which come from firms or individuals that appear to be afraid to follow up an account, if necessary. They get a reputation of being easy, so that their patients or customers do not seem to hesitate in evading an account. Accounts are hard to collect also where a dentist is afraid to try to collect the full amount, and will often allow settlement for a smaller amount than that first demanded. If the account was too high originally, why was such a price charged? Also, if the patient knows that by stalling off the account it is possible to settle for a smaller amount than that first demanded, might you not, if you were in his position, try such a thing yourself?

There are a great number of professional men who will follow up an account about so far, in an effort to collect it, and then drop it for fear of hurting their professional standing or from physical fear. A good thing to consider on that point is the possible attitude the same person you are trying to collect from would show towards you if you owed him an account.

Means of Collection

The way a bill is collected, or should be collected, depends a good deal on the class into which the person is placed by you or other people. Also somewhat upon the community you serve. You would doubtless use quicker and more effective means upon one that might be considered a transient than upon one who had lived in the community a considerable period and had visible assets which you might attach or seize upon if necessary.

To find out the standing of a patient might in some cases be better before trying to collect. Using time and money to collect an account from a proverbial dead beat would surely not be as profitable as using your efforts upon one who would pay or be made to pay.

(To be continued)

Reply to "A Regular Helpmate"

By Mrs. G. H. M.

I am the wife and assistant of a dentist who has practiced for five years in a small town in Nebraska of seven hundred and fifty inhabitants. I am as much of a constant reader of the Dental Digest as my husband is. With pleasure I would like to write my experience as

a dentist's wife in answer to Mrs. S. A. B., of Dallas, Texas, who wrote the article "A Regular Helpmate" in the July number of the DENTAL DIGEST.

As you see I only have five years of experience as a small town dentist's wife, but in that five years I believe (not wishing to be egotistical) I have learned some of the things that the small town dentist and wife have to deal with in order to be a success. Five years ago this month we started in with the determination to be a success in my husband's profession in a country town. We had no capital only health and ambition. We succeeded in borrowing a few hundred dollars to buy the office of an old-time dentist, an office that looked a good deal more like a real estate office than a dentist's office, and also to follow up in the path of a devout believer in treating teeth and gold crowns by the wholesale with his multitude of ardent admirers.

Now, my dear readers, you who have had some such experience will no doubt realize the situation. So with earnest hearts we set to work to change this place of curtainless windows, pictureless walls, sightless window sills that held everything from an ear of corn to forceps, into a dental office. Keep in mind we had very little capital to go on, so I set to work to refinish the old cabinet, remove the unnecessary bric-a-brac, put up attractive curtains, choose a few good pictures, clean out the window sills and give space to an attractive plant, enamel the reception room furniture, and thus a dental office arose out of the chaos. Now that the office was made presentable my husband was ready for business and he decided I should be his assistant until he could afford to hire some one, so I obtained three white uniforms and started in to read and study every article I could find on dental assistants and their duties as it seemed to me that a multitude of things was required of them. Well, I gradually mastered some of them and applied them as best I knew how. It seemed to come fairly easy, for my whole heart was in my work as I wished our work to be a success. I always try to be courteous and thoughtful toward everybody even when they had tried my husband's patience beyond endurance and I would be all ruffled up myself. I always try to study and know our patients so we may know what to expect of them and what they may expect of us in return. All the dental conventions I attend with my husband, and when not listening to a lecture or a clinic I kept my eyes and ears open for any information that might be helpful to apply to our own office, and when we return from a convention I would have nearly as many ideas to apply in our office as my husband.

Now, outside of our office I belonged to a woman's club and one church club, and that was the extent of my social life; it was enough, for I am deeply interested in both and when I did have time to work I put my whole self into it. By taking a real interest in the woman's

club I, of course, became very interested in the schools and was able to do some work along that line that helped them some; the community seeing I was interested took it for granted my husband would be interested and so at the age of twenty-six years he was elected a member of the Board of Education.

In the church work I became acquainted with different people and always tried to be an earnest worker and my husband having the same interests we naturally gained the respect of the people. Now in this public work I never tried to be a leader but a willing worker and not for selfish gains.

Some good reader will say, "Well, how could she be an efficient assistant to her husband and a club woman too?" Most of my club work is outside of office hours and I only attend club on an average of twice a month. Some one will say, "I bet she didn't keep house." Yes I did, too, not a spick and span place, but a homey place for a tired husband and friends occasionally. I always figured that when we were very busy that it was economy to take a meal out now and then.

So at the end of five years we have our office paid for, money out on interest, a good practice and the ambition to specialize so that we may be able to give better service to mankind. I feel that taking everything into account we have gained the honor and respect of the people, or else we should not have been able to succeed thus far. The only reason we would care to move to a larger place would be to obtain a wider range for our work and to specialize.

Now this is the experience of a five year dentist's wife, and it would be great pleasure for me to read an article by some woman of say ten or fifteen years' experience.

Brother Bill's Letters

My Dear Nephew:

Before you can appreciate some of the elements of good office conduct, you will have to accustom yourself to a viewpoint which is common to any well-managed commercial business, even when the executives are the owners. It is that "the business is the thing" of which you are a part and not that you are "the thing" of which the business is a part. The usual professional view is quite the opposite of this and was well expressed by the dentist who said, "What's the use of all this talk about economics? Ain't I the whole thing anyway?" He was "the whole thing," but in his case "the whole thing" was not anything to be especially proud of. And I have noticed that the achievements of those who take that position are rarely great, while, on the contrary, the achievements of those who subordinate themselves somewhat to the business are often noteworthy.

Perhaps I can illustrate what I mean by describing what I understand to be one of the fundamental differences between a great actor and a small one. The mental ability may be equal or even greater in the small actor. But the actor who views everything in relation to his own aggrandizement stays small. He distorts or sacrifices the true interpretation of a part to give it his own interpretation or make himself prominent. The great actor, studying a great part, seeks to rise to a great interpretation for it and pours all that he is and has into that interpretation. He is satisfied that the glory shall be reflected

from the part to him and that each shall build the other up; whereas the small man seeks to win his distinction by the intrusion of his own unsubordinated and perhaps unrelated characteristics, often destructive to a great interpretation.

Nobody has a better chance than yourself to build up an organization of great service value to the public if you subordinate yourself to principles which experience in other lines has proven sound and effective.

If you insist on being "the whole thing," the organization will be no bigger than your untrained and undirected activities. The principles of growth in a business organization have been tested so many thousands of times and analyzed and discussed in such detail that they

"Ain't I the whole thing anyhow?"

are now pretty well known. If you familiarize yourself with these principles and apply them in the measure suitable for your business, you will find yourself able to add to your efforts the efforts of others, who, collectively, will make great contributions.

It is not a case of "letting yourself down from a greater height" to business principles. It is a case of being able to rise to them.

What are these principles as applied to your practice? If I suggest a few, others will occur to you.

You will give your patients the greatest value, per dollar of expenditure, in the long run, when you know that each fee is equal to your cost plus a fair profit.

If you collect Bills Receivable promptly and pay Bills Payable with equal promptness, you will be able to give each patient the unhurried and unworried attention to which he is entitled.

When a patient accepts your fee, you are bound to deliver the quality and quantity of service you sold, whether or not you make a profit.

—seeks to win distinction by the intrusion of his own unsubordinated characteristics.

It is folly to try to make up by overwork what you lose by unprofitable fees. Unless you keep well and have time for study, special courses, meetings, etc., you will be unable to keep up with the advances of the profession and will lose the power to render the kind of service your most desirable patients want.

Your greatest success will be achieved when you are able to render a good quality of service for moderate fees, without overworking, and still earn your comfort and competency.

You can achieve these things only by a good degree of organization and you can perfect the organization only by the guidance of sufficiently extensive and properly kept accounts.

What accounts should be kept as guides? The most important of all is a Profit and Loss account, because, in the end, all the economic activities must take their guidance from the showing in this account.

It is folly to try to make up by overwork what you lose. . . . .

This account is just what the name signifies, a summary which shows whether all the activities have resulted in a money profit or loss. It is rather difficult to keep under ordinary conditions, if one knows nothing of accounting, but in the system we use in the office, it is really very simple, so that I could take off a statement of profit or loss in a few minutes.

The importance of this account has usually been greatly underemphasized in dental accounting. It is lacking in many systems of dental bookkeeping. They distribute expenditures among many kinds

of service and subdivide receipts as finely as heart could wish, but when one finished he didn't know where he was going, financially, or whether he was on his way. A system of bookkeeping without a Profit and Loss account seems to me like a railroad which stopped somewhere in the fields. One could buy a mileage ticket and ride to the track end, but when he got there he wouldn't be anywhere. The Profit and Loss account is the terminal of the road, and few railroads are able to do business without a terminal at which to stop.

My difficulty in learning to keep a Profit and Loss account led to something that may be interesting and helpful to you. My first real

bookkeeping system was made up by a skilled accountant. There were books for this and books for that. After I had studied them for an hour they seemed to be full of the words "debit" and "credit." And these debits and credits chased each other about from book to book in such a bewildering way that I took the books back to him and said they were useless to me, however scientific they might be. I explained that my bookkeeping must be of the primer variety.

So he rearranged the accounts, took out the words "debit" and "credit" and put a circle in place of one and a square in place of the other. Then he spread all the accounts out on one double page, each column on that page taking the place of one of the books in the first set. "There," said he, "that complies with every requirement of scientific accounting and is sufficiently detailed for your needs. Every entry will begin with a charge or a credit to some account. Notice whether a circle or square is at the top of the column where you first enter it. Then make a balancing entry for the same amount on the same line under the other sign (that is, from a circle to a square or a square to

—like a railroad which stops somewhere in the fields.

a circle, but never from a circle to a circle or a square to a square) in what you think to be the proper account. By following the directions at the head of the Expense columns and the Sales column, you will automatically balance the book. The sum of all the 'circle' columns on a page will balance the sum of all the 'square' columns, and thus you will detect errors in entry or additions." In some years of experience, I have found all of his statements to be justified. Any intelligent dental secretary can learn in a few hours how to keep the book, and it is practically self-balancing.

Perhaps the account next in importance to the Profit and Loss account is the Cost account. Experience led me to place this right beside the charge to the patient. From a knowledge of my costs I got courage to replace my traditions-determined-fees fair to the patients and myself. I may add that I only got that courage by many an hour of figuring costs with what knowledge I had, entering the cost on the record and comparing it with the charge against the patient. One of my friends in the profession who went back over his charges with what knowledge he had gained about costs told me he had to quit that study because in the first eighty-four charges he had studied, fifty-two afforded less remuneration above costs than he paid his plumber. My own position was not much better.

I took the books back to him—

Miss Manager is likely to be an excellent investment for you in connection with this column, because it takes a good deal of accounting to get the cost exactly right and I fear you wouldn't do it. The number of income hours, as called for in connection with the Cost column, must be accurately kept and divided into the total costs, to give the office cost per minute.

It will offend your sense of good business conduct to habitually enter costs which are more than the charges, and you will probably begin a more detailed and careful study of all the business activities in the office. It is the purpose of these entries to inspire such study

and direct it. It will be quite an achievement for you when all your charges are slightly higher than the costs. You will then be on the road to undertaking a reduction of costs and charges with a satisfactory final outcome.

—52 of the first 84 charges paid him less than he gave his plumber.

The account which stands third in importance in our office is also unprovided for, at least with sufficient clearness, in most dental accounting systems. It is a Sales account to which can be credited each sale of service. We call it the Professional Service account.

In learning the principles of accounting I was led to the conclusion that I had a stock on hand to be sold, just as real as the shoe dealer's stock, only his was visible and mine wasn't. His consisted of shoes and was sold in boxes and mine consisted of skill and was sold in service. I couldn't find out how to run a Skill Sales account, but I decided that skill could be charged for by the time it took to apply it to any case. This brought me back to the income hour basis, but I sold most of my services by a fee for the operation rather than a time fee, so I didn't want to enter time into this column. I finally imagined this account to be a person into whose charge I gave all the skill I should ever exercise. And every time I took from him some of that skill and sold it, I gave him credit for what I took. So, when I charged

—just as real as the shoe dealer's stock, only his is visible while yours isn't.

a patient with five dollars' worth of service under the circle of the Patients' Accounts column, I gave this fictitious person credit for five dollars' worth of skill under the square of Professional Service column. It helped me quite a little, in the beginning, to personalize all the accounts in this way.

Whenever the book is balanced, entry is made in the circle column of the Professional Service account equal to the amount in the square

column of that account and, according to the directions just over the circle, that amount is transferred to the Profit and Loss account, square column. It then appears to the credit of the practice.

The charges against patients and credits for payments by them are taken care of by the Patients' Accounts column, together with the Cash column which answers the purpose of a separate cash book.

The expenditures of cash may all be kept under Overhead if one desires, but may better be divided among Overhead, Labor and Materials, as shown by the column headings, since excessive costs in any department can be thus more readily detected.

The Property column takes care of the more important items of office equipment and the Bills Payable column records all obligations not immediately paid in cash.

A few hours of practice will make you familiar with all that I have written. My purpose has been to acquaint you at least with the fundamentals and to persuade you to do enough study on your own account so that if you lose Miss Manager, you will not be entirely at sea. If you didn't have her the study would be essential to your own development and the guidance of the practice. It is also essential to the welfare of your patients.

Bill

PRACTICAL HINTS

This department is in charge of Dr. V. C. Smedley, 604 California Bldg., Denver, Colo. To avoid unnecessary delay, Hints, Questions and Answers should be sent direct to him.

NOTE—Mention of proprietary articles by name in the text pages of the DENTAL DIGEST is contrary to the policy of the magazine. Therefore contributions containing the names of proprietary preparations, if published at all, will be altered to the necessary extent; but such information will be given direct by letter when requested.

Editor Practical Hints:

I have two cases concerning which I would like advice.

No. I.—A woman's case presents with bone-like growth in the center of the hard palate. Growth about two centimeters long by one wide by nearly one centimeter high. Has been there all her life. Patient has been told by several dentists that she can never wear plate. She needs her upper teeth out. I have seen a number of these cases but have not been called upon to make a plate for any of them. Will the plate irritate this and cause growth? I can make a plate for the case by the use of relief over the area. What is the history of plates made for such cases?

Case No. II.—Extracted a lower left first molar. Patient failed to show up to have the socket washed out. He got a shot (I suppose from eating game of some sort) in the socket probably within two or three days after extracting. He came up two or three months later with all soreness gone and jaw well healed, but the socket is full depth and lined with a healthy mucous membrane and the shot rolling around down in there. I cleaned it out and destroyed the mucous membrane but had no results. Have done that twice since without results. Can you give me any advice?

ANSWER—The bony prominence described should not be any serious detriment in the fitting of an upper plate to this mouth. Just scrape the impression generously over this area for relief or place a metal relief on the cast and probably you will never hear from the condition later. In some cases where this growth is very prominent I prefer to have it removed surgically, which may be done with no great difficulty and no danger of serious injury to the patient.

Your case No. II is certainly a very unusual condition. By opening the socket up thoroughly and freshening the bone surfaces (instead

of just the mucous membrane) and allowing socket to fill with a normal, clean blood clot you undoubtedly would succeed in having same fill in with granulation tissue followed by normal alveolus enclosed by mucous membrane.—V. C. SMEDLEY.

Editor Practical Hints:

What can I use to avoid the pain caused by forcing the needle in the gums when using a local for extracting?

ANSWER—Swab the gum with alypin a few minutes before inserting the needle.—V. C. SMEDLEY.

Editor Practical Hints:

Will you kindly advise me what style of card to use when notifying patients to call for dental examination?

M. I. EVANS.

ANSWER—Perhaps some other reader will have a better suggestion, but our habit is to tell the patients when we finish a series of appointments that their teeth should be examined again in two or three weeks, three months, six months or whatever period we deem advisable. We then ask them if they would not like to have a definite appointment made ahead at this time for that purpose for which we give them a regular appointment card agreeing to notify them a day or two before. —V. C. SMEDLEY.

Editor Practical Hints:

I am taking the liberty to ask you about a case of bleeding gums. Patient is a man about 38 or 40 years old. His gums bleed at times so profusely that he has to continually apply alum. He admitted to me that he was one of the "bleeder" type, and that when he had extractions some years back, that the dentists had to pack sockets. I scaled his teeth, not finding a very great amount of tartar, but succeeded in starting his gums bleeding and was unable to stop same after applying peroxide, tannic acid and adrenalin chloride. I succeeded, however, in scaling all tartar and trimming rough edges of fillings. I then applied an astringent liquid which is part of the "mercitan treatment," and usually checks bleeding but not in this case.

This patient desires either to be cured of these bleeding gums or have his teeth extracted. Now, in case I must extract these teeth which are sound without any evidence of pyorrhea and are very hard to extract, wouldn't it be the best policy to have him go to a physician a few days before and have some salt solution injected to cause blood to clot? I believe trouble to be a lack of fibrinogen in the blood. Any advice will be greatly appreciated.

R. H. K.

ANSWER—It certainly should not be necessary to extract those sound teeth to stop this bleeding of the gums. I am inclined to think that you are mistaken in thinking that you have succeeded in removing all the tartar and trimmed and polished all rough edges of fillings or rough and etched enamel beneath the gum margins, for if you had removed all such it is certainly not likely that the gums would continue in an inflamed and congested conditions ready to bleed without provocation. I think it is quite likely that you should refer this patient to a pyorrhea specialist for the final scaling and polishing of the necks of the teeth. It, however, would certainly be advisable whether the teeth are to be extracted or scaled to refer the patient to a physician for a blood count with the request that the blood be brought to a normal or at least a safe index of coagulation at the time of operation. Our dental surgeon, Doctor Wyman, makes this injection himself with Thromboplastine with very satisfactory results in practically all instances, but unless you are thoroughly equipped to do this work in a scientific manner it would certainly be best to send the patient to a physician for same.—V. C. SMEDLEY.

CORRESPONDENCE

Editor DENTAL DIGEST:

While it is not my intention to criticise or antagonize any member of my profession or of the Medical profession, I would greatly appreciate having some information regarding this case, and information regarding other such cases should it be obtainable. The case is as follows:

A relative of the family who has been afflicted with deafness for some years informs me of consulting an ear specialist in this city who has the reputation of being the best she could consult. She informs me that during the examination of her ears, nose, throat and oral cavity he condemned the dental profession for using amalgam fillings as replacement for tooth structure which has been lost through caries. He claims that the mercury which is incorporated with this type of filling material acts as a poison to the nerves of the teeth, also has a similar action on the other cranial nerves, and thus attributes part of the deafness to the amalgam fillings found in her teeth. This patient has been recommended by the ear specialist to an ethical dental practitioner here, and he informed her that she will have to have all the amalgam fillings removed, and as her teeth are somewhat brittle and the cavities somewhat large she will have to have them replaced with gold shell crowns, ten in number.

Several months ago I had occasion to examine the oral cavity of the lady, and to the best of my recollection there were several pit cavities which were filled with amalgam among the other work previously rendered.

As an ethical practitioner of the dental profession, I think several of these replacements could be done with gold or porcelain inlays, thus conserving much of the tooth structure, eliminating any danger of infection about the gingiva, eventually resulting in a recession of the gums and a great probability of a loss of the entire tooth. Again, if these teeth are broken down and are nothing but shells, it has been taught in our colleges that building up such teeth preparatory for crowns should not be done with cement, as the cement sometimes washes out, but amalgam should be used as it is more substantial. What would the action of mercury be if a crown is placed over it? It is my opinion that if the mercury incorporated in these fillings would have such an action on the nerves there would also exist some sort of mercurial stomatitis, as these fillings are exposed to the secretions of

the oral cavity, whereby such conditions could easily exist if such were true.

This party was also informed by the ear specialist that he knew of cases where people who were afflicted with troubled eyes had the amalgam fillings removed and replaced with gold. After doing so all the trouble was cleared away without the aid of other treatment for the eyes.

I would like to have all the information and opinions obtainable regarding such cases. L. H. K.

Editor DENTAL DIGEST:

I have read with interest many of the peculiar cases which have been discovered by members of the profession, and which have appeared in your magazine within the last year. I have had little experience as yet as I have another year at the Iowa University Dental College, but while working as an assistant in my father's office we came across a case which I am very sure seldom occurs, and it may be that some of your readers would find it interesting.

Patient called at the office, female, age 55. She complained of having trouble with the upper left third molar. Imagine our surprise on examining to find that she was wearing a full upper denture, and had been for seventeen years. Both third molars were in place, although they were somewhat mesially to their normal position in the arch. They were abraded to a level with the gum tissue, and upon radiographing it was found that there was a small abscess at the apices of the left third molar. The right third molar was putrescent, the pulp chamber being exposed. Here is her story:

Seventeen years ago she had an upper denture made. Her third molars erupted two years later and as they did not cause her any trouble she had nothing done with them. As the teeth slowly came through the denture abraded them down. She stated that at no time had they caused her any trouble except they were slightly sensitive at times. Little of the crowns of either of them was left, and they were somewhat loose. On the palatine surface of the denture two depressions were worn about one-sixteenth of an inch in depth just anterior to the tuberosity. They had at no time caused the denture to become loose, and it was moderately stable when she was here.

The two teeth were extracted, and it was found that little more than roots remained.

It is a mystery to me how they remained there fifteen years without causing more trouble than they did. I should think that it would

be much easier to get gum infection around a tooth under a denture than in a normal case. Also by the appearance of the right third molar it had been exposed for some time, and yet there was no sign of infection of any kind.

D. E. WOODARD.

HAVE YOU A PLACE FOR THIS MAN?

THE INSTITUTE FOR CRIPPLED AND DISABLED MEN

245 East Twenty-third Street, New York City

Editor DENTAL DIGEST:

We are interested in getting a position for John Curley, a young man who has just been graduated from the Y. M. C. A. course in mechanical dentistry. He is an excellent young man with unusual intelligence and skill in this work. He is handicapped in finding a position by deafness. Someone suggested that the DENTAL DIGEST might be willing to help us in placing him in a dentist's office or in a dental laboratory, by printing this letter or an advertisement in the next issue of the DIGEST.

We should appreciate it very much if you have any suggestions to offer us in this matter.

Sincerely,

SYLVIA T. HARRIS,

Employment Secretary.

DENTAL LABORATORIES

A Pleasant Outing

On Saturday, June 24th, The Dental Laboratory Club of New York held its first annual outing at Princess Bay, Staten Island, N. Y. This was the first time a successful attempt had been made on the part of the laboratory owners of New York to go out and spend the day together.

Starting from 40th Street and Seventh Avenue by sight-seeing bus the party motored through picturesque Staten Island to their destination, where a game of baseball was played.

After the ball game all went in for a swim, which was followed by a shore dinner. A few short speeches were made by some of the members, and when the motion was made to adjourn all went back to New York feeling they knew and liked each other better.

It was gratifying indeed to see competitors who had never met, employers and former employees all together for the first time, forgetting their differences, burying the past, and all out to make the affair a great success and to transform new and slight acquaintanceships to a greater friendship from which some good must come.

The closer relationship brought about at this affair should encourage others like it.

The New York Laboratory Club was organized to permit an exchange of ideas among members for the betterment of its service to the dental profession. Some of the most prominent men in the dental profession have appeared at its monthly meetings.

Its membership consists of laboratory owners who are desirous of doing the best work that can be produced by the use of materials of standard quality.

The committee in charge of the affair was G. H. Sternberg and R. G. Skillman.

Officers of the Club: A. S. Van Houten, President; R. C. Supplee, Vice-President; M. Movshovitch, Treasurer; F. A. Baulieu, Secretary.

Board of Directors: G. H. Sternberg, S. G. Supplee, L. A. Kiander.

THE DENTAL LABORATORY CLUB OF NEW YORK

First Outing, June 24, 1922

DENTAL SECRETARIES and ASSISTANTS

Secretaries' Questionnaire

All Questions to be addressed to Miss Elsie Pierce, care of DENTAL DIGEST, 220 West 42d Street, New York City

How are the usual medicament odors prevented?

Clay deodorizers in different designs may be purchased at your supply dealers and filled with antiseptic and aromatic oils. The clay absorbs the odor and will not need renewing for several weeks. Or a jar of colored cubes covered with perfume may be used. The cover should be removed for a half hour each morning. Open all the windows at lunch time and every other time that the chair is vacant.

How are transient examinations taken care of when the appointment book is filled?

Some offices arrange to see examinations only at the last hour of the day. In order to give proper examination and diagnosis a definite time should be reserved. The assistant can get all preliminary information and explain the doctor's procedure.

What can I say to patients who telephone and "must" speak with the doctor?

When you answer, announce the doctor's office, giving your name as speaker. Tell them the doctor is operating, and ask if you may take the message. They will no doubt give the name. If it is someone for whom the doctor would not care to be disturbed, ask if there is any way in which you can serve, otherwise ask for the telephone number and say you will call back when the doctor is at leisure.

How can canal points be kept sterile?

In a sealed glass container, divided into compartments for the different sizes. Glue cotton to the cover and moisten with Dakin's solution.

How can a stock closet be kept in order?

List the articles on hand as well as articles always needed—alphabetically; mark quantity on hand after each item. When anything is removed make a note of what is taken and quantity left. Then when the salesman calls or you telephone an order, it will take but a moment

to look at your list and refresh your memory as to what is needed. Tack the stock list to closet door. If an inventory is taken every month, as it should be, your list can be changed then and kept neat and in proper order.

What should be the proper appointments in a retiring room?

The modern office should contain a dressing room and a rest room. The dressing room should contain simply a dressing table, chair and place for hanging wraps, so that patients may enter the chair and leave the office knowing their appearance is correct. It would hardly be comfortable for a patient needing a half hour's rest to retire on a decorative chaise lounge, with the next appointment arriving and hanging a wrap on the costumer. A sanitary-covered couch in the surgical room or one of the operating rooms, with a screen near at hand, would be better.

Is it proper to wear a cap?

That is a personal matter for the assistant or doctor to decide. If you are a chair assistant, a white cap and white shoes and stockings add professional dignity. In an office where several girls are employed, the secretary will best serve in a serge dress with white collar and cuffs, or a white shirtwaist with high collar and a dark skirt.

Should an assistant (not a hygienist) be permitted to clean children's teeth?

This is prohibited by law. Prophylaxis is of much importance and should not be thought so lightly of as to trust to some one not trained to its importance or procedure. An assistant may be of help in delivering a prophylactic lecture or demonstrate the proper method of daily home cleansing.

If a patient came in to the office and asked the price of a small amalgam filling, would you, knowing the doctor's schedule, tell her?

It hardly seems possible that a definite fee can be arranged without examination. What may appear to be a simple fissure cavity, may take several visits. Also the doctor might suggest a gold or porcelain inlay. Always advise that the doctor must give his personal diagnosis and attention.

How may the reception room be kept in order?

If the woodwork is ivory or white enamel it can be cleaned with a damp cloth. A base moulding of mahogany will add to the attractiveness of the room and prevent the discoloring of the wood from the oil or wax mop. A painted, stippled wall in ivory or gray lends itself to any color scheme or furniture. One or two floor lamps or lanterns add color. For shades, use parchment or plain gold silk. Avoid elaborate

designs, fringes and tassels. For pictures, etchings framed in dull gold or black ebony are sure to be in good taste. Have black leather binders made for the magazines that are subscribed for. The manufacturer will print the magazine name and the doctor's name in gold on the covers. Then be sure to change the issue each month. Your reception room table will always be in order and the magazines will last and not be torn or mutilated. Sash curtains of marquisette or dotted swiss seem most appropriate for a professional office and can easily be laundered. If your walls and rugs are one-toned, curtains of cretonne or chintz add a cheerful note.

How can broken appointments be avoided?

If you will hang a framed sign at the desk where appointments are arranged, saying: "Dental service must be rendered by appointment, and broken appointments will be charged for unless suitable cancellation is received," and also giving an appointment card for all time reserved, they will be reduced to the minimum. When patients telephone to cancel an appointment, always ask if they wish to reserve another appointment at that time and have the appointment book at hand so that it can be noted. Then mail a card verifying the hour and date.

What is the proper time to keep instruments in the sterilizer?

If the solution is boiling when the instruments are placed in sterilizer, five minutes is safe, but they may be left in a longer period. A 2% solution of sodium carbonate will prevent the instruments from rusting and hasten sterilization. Always protect edges of lancets and cutting instruments with gauze or cotton. If preparing for a surgical operation remove instruments (using sterile gloves), rinse in alcohol, and wrap in sterile gauze.

To Unknown Correspondent

The lady assistant who wrote a letter to the editor August 15th and feared to sign her name lest she lose her position might have signed it in confidence that her name would have been held confidential and her position protected.

The editor would like to publish parts of that letter, but it is against the policy of the magazine to publish anonymous communications.

EXTRACTIONS

No Literature can have a long continuance if not diversified with humor—ADDISON

Everyone admires pure grit, except in spinach.

(Visitor)—What became of that "Dangerous Curve—Drive Slowly" sign they used to have at this point?

(Native)—Oh, they had it there for five years and there warn't no accidents, so they took it down.

(Boy Scout—to old lady)—May I accompany you across the street, madam?

(Old Lady)—Certainly, sonny. How long have you been waiting here for someone to take you across?

(Lady)—Is this a pedigreed dog?

(Dealer)—Pedigreed! Why if that there dorg could talk he wouldn't speak to either of us.

"Are you a messenger boy?"

"No, sir. I gotta sore toe, which makes me walk slow like this."

(Teacher)—Can you tell me the shape of the world?

(Pupil)—Pop says it's in a hell of a shape!

"Wifey seems to be fond of an argument."

"Fond of an argument! Why, she won't even eat anything that *agrees* with her."

(Griggs)—Is Billson a careful driver?

(Briggs)—Very much so. He always toots his horn before crossing a railroad track. That leaves the railroad no chance for damages if an oncoming train is smashed up by his flivver.

Lightning knocked a Kansas man out of his bed, and, according to the report, the first words he said were: "All right, dear, I'll get up."

"I have a gallon of alcohol," said Blinkins, "but there is so much of this wood alcohol floating around I'm afraid to use it. Do you know of any good test for a case like this?"

"Sure I do," answered Filkins. "Strain it through a piece of cheese cloth, and if you find any splinters, it's wood alcohol."

NOMENCLATURE

Father calls me William,
Mother calls me Will,
Sister calls me Willie,
But the Elks say, Hello, Bill!

(Eve—in the garden)—But really, Adam, I have nothing to wear!

(Adam—soothingly)—That's all right, my dear; you are setting the style for 1922!

The irate shopper was returning an unsatisfactory purchase.

"You told me these were fast colors," she complained, "and the very first time they were washed they ran."

"Maybe you didn't use stationary tubs," suggested the sweet young thing behind the counter.

I used to write her of her eyes,
Her hair, her wondrous voice;
In verse I wooed her tenderly—
The lady of my choice.
And so I won her; but today
This fairest of her sex
Cares little what I write in verse
If I will write her checks!

(Mother)—Didn't I tell you not to go swimming?

(Billy)—Yesum, but the other kids pushed me in.

(Mother)—How does it happen that your clothes are not wet?

(Billy)—When dey said dey was goin' to push me in, I took 'em off!

(Tony writes a letter)—Louisiana Hdwe Co Deer Fren. I got the valve witch I by from you alrite, but why for gods sake you doan sen me handel. What the use the valva when she doan have no handel. Is my money not so good to you as the other feller. I wate 10 days and my customer he holler for water like hell for the valva. you know is hot summer and the wind he not blow the wheel you doan send me the handel pretty queek I send her back and i order some valva from kraine companies.

Goodby, your fren Antonio Giusepte Datra.

Since i write these i fin the goddam handel in the box, excuse me.

DIETETICS and HEALTH

Health Secrets Revealed by Animals

The anti-vivisectionists are not so active now, since the public has begun to understand that an experiment with an animal may save the lives of thousands of children.

Were it not for this some of these well meaning but misguided people might be trying to interfere with the experiments in the feeding of rats, which in recent months have so enlarged our knowledge of the art of nutrition.

One wonders why rats are used for these experiments, says "Healthy Home." The reason is because these animals eat almost anything, need little food and space for housing, and have a short life-cycle.

It might be added that if properly housed in clean cages, rats are comparatively immune to infectious diseases, and animals of the same colony show rather uniform rates of growth. This makes it possible to detect retarded development due to a deficient diet by comparison with normal rate of growth. All animals on experimental diets are weighed twice a week and careful records are kept.

By simple food analyses, we can determine the amount of protein, but it does not tell us the quality of that protein; i. e., the kind of building blocks from which it is made. A contractor cannot build a stone house when the material supplied him is mostly brick. Likewise, if the protein of the food does not contain the building blocks from which body protein may be constructed, then the protein is of poor quality.

Rats fed on a diet adequate in every respect except the quality of the protein, will very soon show symptoms of malnutrition, retarded development, rough coat, unkempt appearance. Thus the rats have told a story which the chemist could not easily discover.

In a similar way the chemist may tell us the total ash of a food or even the individual inorganic elements present in that ash, but that does not always satisfy the physiologist that those mineral salts are present in a suitable form for the animal organism to use. Numerous experiments have demonstrated that lack of calcium (lime) in the food leads to a soft condition of the bones, with resulting humpback

and otherwise deformed animals, or that lack of iron in the food results in anemia. Thus while Chemistry can give us figures, Physiology with the help of the rats gives us striking demonstrations of the need of various constituents in the diet.

Of the three vitamines commonly recognized at the present time, namely, fat-soluble A, or antirachitic; water-soluble B, known either as antineuritic or "growth promoting"; and water-soluble C, the antiscorbutic, the first two only are essential in a rat's diet. When vitamine A is absent from the diet, growth may be normal for a while, but will eventually be retarded, and frequently an eye disease develops. Absence of vitamine B from the diet inhibits growth almost immediately, and rapid decline results.

Visualizing Our Composition

In medicine we often get so close to the details that we do not see the whole; so close to the forest that we cannot see the woods for the trees. This is especially true in respect to things that are examined with the microscope or determined by microchemical methods. Luden has called attention to this tendency, and points out a number of quantitative facts that are somewhat startling, says the Journal of the A. M. A. For example, the entire volume of circulating blood, which about half fills an ordinary bucket, contains only a small teaspoonful (from 4 to 6 gm.) of sugar and a tablespoonful (32 gm.) of salt. When we consider the minute variations in the sugar content that the modern chemist can measure in a few drops of blood, we gain added respect for the science of quantitative analysis. The iodin in the entire blood amounts to but 0.01 gm., or an average dose of atropin. When the physiologist tells us that epinephrin can be detected by biologic methods in a dilution of 1 : 330,000,000, it means far less than to say that it is equivalent to diluting "a small glass of whisky (10 c.c.)" —a very small glass, that—into the contents of 1,320 city street sprinkling carts, which would form a procession about six miles long. We all know that the normal blood contains about 5,000,000 red corpuscles in each cubic millimeter, but do we all realize that the entire blood must therefore contain some 25 trillion (25,000,000,000,000) red cells and 30 billion leukocytes, figures that have an astronomical aspect? And do we realize that in all that mass of blood is distributed the insignificant quantity of from 1 to 3 grains (65 to 200 mg.) of uric acid, which we assay accurately and speculate about vaguely? Luden quotes an amusing, if not very precise, estimate of the total chemical composition of "the average man," which has recently been published

by a big industrial company, and which may be thus summarized: fat enough for seven bars of soap; iron enough for a medium-sized nail; sugar enough to fill a shaker; lime enough to whitewash a chicken coop; phosphorus enough to make 2,200 match-tips; magnesium enough for a dose of magnesia; potassium enough to explode a top cannon, and sulphur enough to rid a dog of fleas. Many items in this estimate are left largely to the imagination, such as the size of the dog and the number of his tormentors, but the total cost of the ingredients is given as 98 cents, which is neither expensive nor calculated to foster megalomania. The practical value of visualized scientific data lies not only in the stimulation of memory through the imagination, but also in the food for thought which they offer and in their bearing on great medical problems. If mental pictures of the billions and trillions of blood cells crowding, jostling, and possibly struggling for a share of the mere teaspoonful of sugar in the total blood volume of a full-sized man, or the endless procession of sprinkling carts representing the epinephrin concentration to which animal tissues respond, appeal to one's sense of humor, they also do much more than this: They bring home the delicacy of the adjustment by which the human body mechanism is regulated; the extent to which this fine adjustment may be disturbed by seemingly trivial factors; the obligation of both laymen and physicians not to ignore the "slight" tokens of distress of the body engine, and the value of comparing the quantities used in the body chemistry with the "dosage" in therapeutics.

The Newer Knowledge of Nutrition

By Elmer V. McCullom, Ph.D., Baltimore, Md.

This book, published by The Macmillan Company, New York, should form part of the library of every dentist who desires to serve as adviser to his patients on the matter of diet for adults or children, or who is himself suffering from digestive disturbances which may be the result of faulty feeding.

The book is a scholarly presentation of information on the subject described by the title, and there is in it much that the dentist will not need and cannot use, since it is not addressed especially to dentists, but there is in the main portion of the book a very large amount of information which should be in the possession of every person who desires to serve as a food adviser or to get for himself the maximum benefits from his food.

Three points are of especial interest:

A diet cannot be successfully made up on the basis of the chemical analysis of food materials. Serious errors have been made in an attempt to feed animals and persons on diets determined by chemical analysis of the food materials.

The most intelligent and successful method of testing the food value of different materials is to feed them to animals and watch the results. This is the manner followed in developing the material in the book. The feeding should be continued until its effect on bearing and raising young is seen, since valuable additional knowledge is gained in this way.

A vegetarian diet for man does not afford the necessary food elements in necessary quantities. It is injurious to the individual and if persisted in to the degree sought by the so-called "food reformers" threatens disaster to that portion of the race they are able to persuade. Certain meats, milk and certain vegetables form a sufficient diet, to which one may add what fancy dictates, within reason.

The last chapter of the book, "The Problem of Preventive Dentistry," is of particular importance to every dentist. It deals with the problem of physical inferiority in childhood, presents the claim that proper nutrition is the basis of preventive dentistry and suggests a simple diet for children which will prove of maximum value.

If the dentist is to rise to the possibilities of service which his profession not only makes possible but, in a manner, obligates him to at least try to fill, he must be able to advise parents of physically inferior children as to those steps which will supplement his efforts to develop for them optimal physical conditions. This book will provide him with information of great value in this field.

G. W. C.

FUTURE EVENTS

THE CONNECTICUT DENTAL COMMISSION will meet at Hartford, Conn., on November 23rd, 24th and 25th, 1922, to examine applicants for license to practise Dentistry and Dental Hygiene, and to transact any other business proper to come before them. For further information apply to Arthur B. Holmes, 63 Bank Street, Waterbury, Conn.

The Fourth Annual Meeting of the AMERICAN ACADEMY OF APPLIED DENTAL SCIENCE will be held at Miami, Fla., January 8, 9, 10 and 11, 1923.

All ethical students of progress in both the medical and dental professions are invited to take this short course in Orology—Health Dentistry. Papers, clinics and some educational classes free.

For information write Convention Headquarters, American Academy of Applied Dental Science, Congress Building, Miami, Fla., or Chamber of Commerce, Miami, Fla.

DR. H. D. MADISON, *Corresponding Secretary,*
Burlington, Iowa.

The annual midwinter clinic of the CHICAGO DENTAL SOCIETY will be held at the Hotel Drake, January 18, 19, and 20, 1923.

All members of the National Dental Association are invited to attend. Ethical non-member practitioners, making application for membership at this meeting, will be admitted.

Hotel reservation should be made direct with the hotel management.

For further information, please communicate with

M. M. PRINTZ, *Secretary,*
25 E. Washington St., Chicago.

The sixteenth annual meeting of the MARQUETTE DENTAL ALUMNI ASSOCIATION will be held at the Auditorium, Milwaukee, Wis., February 14, 15 and 16, 1923. All ethical members of the profession are cordially invited to attend.

Dr. G. W. Wilson, 3401 Lisbon Avenue, Milwaukee, is Chairman of the Exhibits.

J. V. SENGPIEL, *Secretary,*
695 Astor Street, Milwaukee, Wis.

THE MICHIGAN STATE DENTAL SOCIETY will hold its annual Convention on March 27th to 31st, 1923, in Detroit. For information, write Bion R. East, 504 Fine Arts Building, Detroit, Mich., Chairman Local Arrangements Committee.